

**Family Care Plus Physical Therapy & Wellness**  
Patient Registration Form (please print)

Today's date:    Diagnosis: \_\_\_\_\_ Primary care physician: \_\_\_\_\_

**Patient information**

Title	Last Name:	First:	Middle:	Social security number/ID
_____	_____	_____	_____	<input type="text"/> <input type="text"/> <input type="text"/>

Other Names: \_\_\_\_\_ Date of birth:    Age: \_\_\_\_\_

Driver's license #: \_\_\_\_\_ Home phone/Contact #:


Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Phone:

Why did you choose Family Care Plus Physical Therapy?  \_\_\_\_\_

Person responsible for bill: \_\_\_\_\_ Contact phone:

**Insurance information** (Please give your card to the receptionist) Work status:

**Physical Therapy bill payment options:** Please select from the drop down box  \_\_\_\_\_

Primary insurance: \_\_\_\_\_ Contact phone number:

Subscriber name: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Authorization required: \_\_\_\_\_ Authorization #: \_\_\_\_\_ Co-pay amount: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Patient's relation to subscriber: \_\_\_\_\_ Any litigation involved due to your current medical issues: \_\_\_\_\_

Emergency contact name: \_\_\_\_\_ Phone:

**Consent for Physical Therapy:** I hereby give consent to the professional staff at Family Care Plus Physical Therapy & Wellness, LLC to deliver required physical therapy care for my condition. Such care can include: physical therapy evaluation procedures, therapeutic exercises, patient education, and specialized techniques including manual therapy as well as modalities as needed.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Family Care Plus Physical Therapy & Wellness, LLC. I understand that I am financially responsible for any balance. I also authorize Family Care Plus Physical Therapy & Wellness, LLC or my insurance company to release any information required to process my claims.

**Medicare patients only:** Have you received Physical Therapy/Speech Therapy services this calendar year?

If yes, has your Medicare Cap been met?

 Patient/Guardian signature  Date:

## Family Care Plus Physical Therapy & Wellness Privacy Practices

This notice describes how medical and personal information about you may be used or disclosed, and how you can obtain an access to this information. Please review this form carefully. Please feel free to talk to us if you have any questions.

### Our legal duty:

Family Care Plus Physical Therapy & Wellness, LLC is required by law to protect the privacy of your personal and health information, provide notice about our information management practices, and follow the information protocols described below.

### Uses and disclosures of health information:

Family Care Plus Physical Therapy & Wellness, LLC uses your personal and health information primarily for treatments, obtaining payments for treatments, conducting internal administrative activities, educational purposes, for quality reviews, and utilization assessments. We use your personal information to contact you to arrange appointments with us, follow ups on your therapy treatments and for properly billing your insurance carrier for the services we provide to you. In addition, we may, time from time, disclose your health information without prior authorization for public health purposes to only appropriate authorities, audit tracking and research studies. In any other situation, Family Care Plus Physical Therapy & Wellness, LLC will obtain your written permission and before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to cease future disclosure at any time. If and when any changes are made in our privacy and confidentiality policies, a new Notice of Privacy Practices will be posted in our practice area for public view. You may request a copy of our Notice of Information Privacy Practices at any time by coming in person, by a telephone call, or by a fax request.

### Patient's individual rights:

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccuracies and any incomplete information in your records relevant to your condition for which you received therapy services. You also have the right to request a list of instances where we disclosed your personal health information for reasons other than for treatments, payments, and other related administrative purposes. You may request in writing that we not use or disclose your personal health information for treatments, payments, or administrative purposes except when specifically authorized by you, when required by law, or in an emergency. Family Care Plus Physical Therapy & Wellness, LLC will consider all such requests on a case-by-case basis. The company is not legally required to accept all requests.

### Concerns and complaints:

If you are concerned that Family Care Plus Physical Therapy & Wellness, LLC may have violated your privacy rights or if you disagree with any decision pertaining to access and disclosure of your personal health information, please contact us immediately at our office. You may also file a written complaint to the U.S. Department of Health and Human Services.

### Family Care Plus Physical Therapy & Wellness, LLC

G-2037 South Center Rd, Suite A, Burton, Michigan 48519  
Telephone: (810)743-7950 Fax: (810)743-7951

## Acknowledgement of receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices at Family Care Plus Physical Therapy & Wellness, LLC and that I have read (or had the opportunity to read if I so choose) and understand the Notice.

## Authorization to release medical records

I hereby authorize release of my medical records required for my therapy needs to:

### Family Care Plus Physical Therapy & Wellness, LLC

G-2037 South Center Rd  
Suite A  
Burton, Michigan 48519  
Telephone: (810)743-7950  
Fax: (810)743-7951

Today's date:

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Name of person: \_\_\_\_\_

Date of Birth:

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Signature/Guardian signature: